Resection of Recurrent Carcinoma of The Esophagus

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THERE HAS BEEN A GROWING FEELING recently among surgeons that carcinoma of the esophagus is an incurable lesion and that only palliative operation is indicated, if any. It is true that surgical cure is relatively rare, but palliation by resection is common. Following is a report of a case in which, following resection known to be inadequate, reoperation could not be done immediately because of the condition of the patient. Resection was carried out again 15 months later when symptoms of recurrence developed, and thereafter the patient was asymptomatic.

REPORT OF A CASE

The patient, a man 59 years of age, was admitted to hospital Nov. 30, 1949, with a history of difficulty in swallowing which had begun suddenly after a scare, four and one-half months previously. Since then the patient had ingested only liquids and the body weight had decreased ten pounds.

Upon x-ray examination with barium swallow, a constricting lesion of the mid-esophagus was noted. Esophagoscopic examination was carried out and a stenotic lesion was observed 39 cm. from the incisors. Squamous cell carcinoma of the esophagus was diagnosed by biopsy.

At operation a 3x4 cm. tumor of the esophagus was observed below the aortic arch without evidence of regional extension. The esophagus was resected from 5 or 6 cm. above the lesion to the stomach. The stomach was mobilized and anastomosed to the esophagus below the aortic arch. In pathological examination of frozen sections of the removed specimen no evidence of tumor was noted at the margins. The postoperative course was very stormy, owing to pneumonia and particularly to auricular fibrillation and flutter. The patient was treated with digitalis and quinidine. He remained critically ill for about one month. The cardiac irregularity was controlled but the patient continued unable to eat and his condition continued to deteriorate until quinidine was discontinued. He then began to recover and soon was eating and feeling well.

When examination of permanent pathological sections was carried out, residual tumor extending to the margin of the resected specimen was noted in one small subepithelial focus, but it was felt that further operation was not indicated at that time because of the greatly increased operative risk and the lack of definite proof of residual tumor. The patient ate well and remained asymptomatic until January, 1951, when frequent regurgitation occurred and the body weight decreased eight pounds. Upon x-ray examination a 2.5 cm. well-defined napkin-ring defect was observed at the lower end of the esophagus at the esophagogastric anastomosis. A biopsy specimen was taken from a tumor observed by esophagoscope 26 cm. from the incisors, and it was reported as squamous cell carcinoma.

Thoracotomy was done March 7, 1951, and a recurrent tumor 3 to 4 cm. in diameter was observed at the site of anastomosis. It was adherent to the aortic arch and hilum of the lung. The tumor was resected and anastomosis was carried out anterior to the aortic arch after frozen sections revealed adequate margins on both ends of the specimen.

The patient did well until the sixth postoperative day. Then tension pneumothorax on the left side developed, apparently owing to leakage at the site of anastomosis. Insertion of a tube intercostally relieved the condition, but on the following day bronchoscopy was necessary for relief of atelectasis of the right lower lobe. Purulent fluid drained from the intercostal tube. On March 17, jejunostomy was done and a tube was inserted for feeding. Homogenized milk only was infused. Nothing was given by mouth. On March 27 auricular flutter developed. It was eventually controlled by administration of digitalis and quinidine. On March 28, rib resection was carried out to drain the area of empyema and the intercostal tube was removed.

The anastomotic fistula healed gradually. Oral feeding was begun again and the patient was eating a soft diet by April 14, 1951. The tube to the jejunum was subsequently removed, and the patient was discharged from the hospital on June 1, 1951. At that time, the lung was expanding to obliterate the space at the site of empyema and the patient was eating well and gaining weight. He was examined at frequent intervals thereafter. He returned to work as a plumber in March, 1952. Gastrointestinal x-ray studies in July, 1952, showed only some scarring at the anastomosis, and there was no change from the preceding gastrointestinal series. The patient said he felt well and ate well. At last report, September 24, 1953, the patient was asymptomatic and was working full time.

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Diagnosis of Subdiaphragmatic Abscess By Needle Biopsy of the Liver

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IN A CASE in which neither clinical observation nor laboratory studies had given any indication of the presence of the lesion, subdiaphragmatic abscess was diagnosed after examination of a biopsy specimen taken by needle from the liver. The procedure caused no untoward complication.

CASE REPORT

A 55-year-old man was admitted to hospital with complaint of epigastric burning sensation after meals for two years, a loss of 20 pounds in weight in six months, and melena and weakness of two weeks' duration. He was obese, pale and apparently acutely ill. The blood pressure was 120 mm. of mercury systolic and 70 mm. diastolic, the pulse rate 100 per minute, and the temperature 99 degrees F. The abdomen was distended and a mass was felt in the epigastric area. The liver was palpable three fingerbreadths and the spleen one fingerbreadth below the respective costal margins.

Erythrocytes numbered 2,280,000 per cu. mm. and the hemoglobin value was 52 per cent. Leukocytes numbered 9,600 per cu. mm. and the cell differential was within normal range. No abnormality was noted in urinalysis. The result of a serologic test for syphilis was negative. An obstructive pyloric lesion with 80 per cent retention of barium was observed roentgenographically.

At operation a large annular metastatic antral adenocarcinoma arising from the head of the pancreas was observed and total gastrectomy, splenectomy, esophagojejunostomy, and entero-enterostomy were carried out.

In the postoperative period the patient had low-grade jaundice and pleural effusion on the left side. He was dis-

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